

to family income level that are described in § 447.78(c) of this chapter, including the period and periodicity of those determinations.

(c) The schedule of the copayments, coinsurance, deductibles, or similar cost sharing charges imposed for each item or service for which a charge is imposed.

(d) The methodology used by the State to identify beneficiaries who are subject to premiums or cost sharing for specific items or services and, if families are at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid defined at § 447.78, track beneficiaries' incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform beneficiaries and providers of beneficiaries' liability and notify beneficiaries and providers when individual beneficiaries have incurred family out-of-pocket expenses up to that limit and are no longer subject to further cost sharing for the remainder of the family's current monthly or quarterly cap period.

(e) The process for informing recipients, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals in accordance with § 447.76.

(f) The methodology used to ensure that:

(1) The aggregate amount of premiums and cost sharing imposed under section 1916 and section 1916A of the Act for all individuals in the family enrolled in Medicaid with family income above 100 percent of the Federal poverty level (FPL) does not exceed 5 percent of the family's income of the family involved.

(2) The aggregate amount of cost sharing imposed under section 1916 and section 1916A of the Act for all individuals in the family enrolled in Medicaid with family income at or below 100 percent of the FPL does not exceed 5 percent of the family's income of the family involved.

(g) The notice of, time frame for, and manner of required cost sharing and the consequences for failure to *pay*.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30262, May 28, 2010]

§ 447.70 General alternative cost sharing protections.

(a) States may not impose alternative cost sharing for the following items or services. Except as indicated, these limits do not apply to alternative cost sharing for prescription drugs identified by a State's Medicaid program as non-preferred within a class of such drugs or for non-emergency use of the emergency room.

(1) Services furnished to individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, including services furnished to individuals with respect to whom child welfare services are being made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Preventive services, at a minimum the services specified at § 457.520, provided to children under 18 years of age regardless of family income, which reflect the well baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.

(3) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.

(4) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act).

(5) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if the individual is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(6) Emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a), except charges for services furnished after the hospital has determined, based on the screening and any other services required under § 489.24 of this chapter, that the individual does

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not need emergency services consistent with the requirements of paragraph (b) of this section.

(7) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and other pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.

(8) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions).

(9) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act, in accordance with the Family Opportunity Act.

(10) Items and services furnished to an Indian directly by an Indian health care provider or through referral under contract health services.

(11) Preferred drugs within a class, or drugs not identified by the State's Medicaid program as a non-preferred drug within a class, for individuals for whom cost sharing may not otherwise be imposed as described in paragraphs (a)(1) through (10) of this section.

(b) For the exempt populations specified in paragraph (a) of this section, a State may impose nominal cost sharing as defined in § 447.54 of this chapter for services furnished in a hospital emergency department, other than those required under § 489.24, if the hospital has determined based on the medical screening required under § 489.24 that the individual does not need emergency services as defined at section 1932(b)(2) of the Act and § 438.114(a), the requirements of § 447.80(b)(1) are met, and the services are available in a timely manner without cost sharing through an outpatient department or another alternative non-emergency health care provider in the geographic area of the hospital emergency department involved.

(c) In the case of a drug that a State's Medicaid program either has identified as a preferred drug within a class or has not otherwise identified as a non-preferred drug within a class,

cost sharing may not exceed the nominal levels permitted under section 1916 of the Act as specified in § 447.54 of this chapter. Cost sharing can be imposed that exceeds the nominal levels permitted under section 1916 of the Act for drugs that are identified by a State's Medicaid program as non-preferred drugs within a class in accordance with section 1916A(c) of the Act.

(d) In the case of a drug that is identified by a State's Medicaid program as a non-preferred drug within a class, the cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing physician determines that the preferred drug for treatment of the same condition either would be less effective for the individual or would have adverse effects for the individual or both.

(e) States may exempt additional individuals, items, or services from cost sharing.

[75 FR 30263, May 28, 2010]

§ 447.71 Alternative premium and cost sharing exemptions and protections for individuals with family incomes at or below 100 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income is at or below 100 percent of the FPL.

(b) The State may not impose cost sharing under the State plan on individuals whose family income is at or below 100 percent of the FPL, with the following exceptions:

(1) The State may impose cost sharing under authority provided under section 1916 of the Act and consistent with the levels described in such section and § 447.54.

(2) The State may impose cost sharing for non-preferred drugs that does not exceed the nominal amount as defined in § 447.54.

(3) The State may impose cost sharing for non-emergency services furnished in a hospital emergency department that does not exceed the nominal amount as defined in § 447.54 as long as the services are available in a timely manner without cost sharing through an outpatient department or other alternative non-emergency services health care provider in the geographic